STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155605	A. BUILDING 01 B. WING	06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTH & REHABILITATION CENTER	1959 E COLUMBUS ST MARTINSVILLE, IN46151

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/07/11 Facility Number: 000400 Provider Number: 155605 AIM Number: 100266880 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Grandview Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 80 and had a	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.This plan of correction is prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	census of 65 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/13/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating for the ceiling in 1 of 2 mechanical rooms with natural gas fired water heaters. This deficient practice could affect any resident, staff or visitor in the vicinity of the mechanical room by the east nurse's station.	K0025	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed. The smoke barrier was immediately fixed upon life safety exiting the building. The hole inthe ceiling was dry walled and painted. All other smoke barriers were inspected and found to be in-compliance. 2. All residents have the potential to be affected. See below for corrective measures.3. The maintenance	06/24/2011

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	Findings include: Based on observation during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., the mechanical room by the east nurse's station which contains three natural gas fired water heaters had an eight inch diameter opening in the ceiling into the attic above the middle water heater. Based on interview at the time of observation, the Maintenance Director acknowledged the mechanical room by the east nurses' station had an eight inch opening in the ceiling into the attic. 3.1-19(b)		supervisor was re-educated on the requirements of K0025. A quality assurance monitoring tool has been implemented and will be completed weekly x 4 wks and monthly x 3 months and quarterly there after until compliance has been mainained for 2 consecutive quarters. See attachment A. 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 6/24/11.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the	K0029	The facility will ensure this requirement is met through the	06/24/2011

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	facility failed to ensure 2 of 2 doors serving hazardous areas such as laundry rooms are equipped with self closing devices on the door which securely latches into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the laundry room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., the laundry room corridor door by Room # 12 is equipped with a self closing device but it did not close and latch securely into the door frame. The laundry room corridor door by the east facility exit is not equipped with a self closing device but did latch securely into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the laundry room corridor door by Room # 12 self closed but did not latch into the door frame, and the laundry room corridor door by the east facility exit is not equipped with a self closing device. 3.1-19(b)		following corrective measures:1. No residents were harmed. Immediatly following life safety surveyor exit, new door closures were installed on both doors and repaired the doors to working condition. 2. All residents have the potential to be affected. See below for corrective measures.3. The maintenance supervisor will be re-educated on the requirements of K0029. A quality insurance monitoring tool will be completed weekly x 4 wks then monthly x 3 months and quarterly until compliance has been maintained for two consecutive quarters. See attachment B.4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meeting and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before June 24, 2011.	
K0038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			

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	Based on observation and interview, the facility failed to ensure 7 of 7 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., all seven facility exit doors are equipped with electromagnetic locks which remained locked when the fire alarm was activated and silenced, but not reset at 1:15 p.m. Based on interview at the time of observation, the Maintenance Director	K0038	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed. Immediatley following the life safety exit, Koorsen's Fire and security were called and came to the facilty to check the exit doors and alarming system. On 6/28/11 Koorsens sent proposal for a latching relay. 2. All residents have the potential to be affected. See below for corrective measures.3. Koorsens educated the maintence director on the life safety doors. See attachment C. Koorsens to provide and install latching relay and normally closed reset button to trigger existing fire door relay. This will latch and stay latched keeping the fire doors unlocked until reset button is activiated. Therefore silencing the panel will not release fire door relay. Maintance will monitor with the quality assurance audit tool weekly x 4 weeks, monthly x 3 months and quarterly until 2 consecutive quarters are in compliance. See attachment D. 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 7/1/11.	07/01/2011

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	acknowledged all seven facility exit doors electromagnetic locks should have unlocked when the fire alarm was activated, then remained unlocked when the system was silenced but not reset. 3.1-19(b)			
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from the weather. NFPA 99, 4-3.5.2.2 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure	K0076	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed. 2. All residents have the potential of being affected. A tarping system was installed to protect the oxygen tanks from all weather conditions. 3. The maintenance supervisor was re-educated on the requirements of K0076. A quality assurance montioring tool has been implemented and will be completed weekly x 4 wks and	06/24/2011

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	to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice could affect any resident, staff or visitor in the vicinity of the exterior oxygen supply location near the exit of the facility by Room #112. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., seven 180 liter liquid oxygen tanks were located in a exterior chain link enclosure outside the facility near the exit by Room # 112. The enclosure was not protected from sun, snow, or rain. Based on interview at the time of observation, the Maintenance Director acknowledged liquid oxygen storage tanks in the exterior oxygen supply storage location were exposed to all types of weather. 3.1-19(b)		monthly x 3 months and quartly until 2 consecutive quarters of compliance are maintained. See attachment E. 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before 6/24/11.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to	K0144	The facility will ensure this requirement is met through the following corrective measures:1. No residents were harmed.2. All residents have the potential to be	06/24/2011

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	the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the "Generator Log Weekly/Monthly" documentation with the Maintenance Director during record review from 9:58 a.m. to 11:45 a.m. on 06/07/11, the emergency generator was run on a monthly basis for at least thirty minutes each month for the period of 12/02/10 through 05/24/11 but the the logs utilized by the facility did not record the time to transfer power from the main source to the emergency generator. Based on interview at the time of record review, the Maintenance Director acknowledged the transfer time to transfer power to the emergency generator was not recorded for each month. 3.1-19(b)		affected. See below for corrective measures.3. A new form was initiated to ensure compliance with the generator transfer time of 10 seconds. This form will be utilized on all routine maintance inspections of the generator and the maintenance supervisor was educated on the use of the form. See attachment F. 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meeting and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before 6/24/11.	

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